APPENDIX A
ATTESTATION OF SURGICAL MEMBER OF AN
AMERICAN CLEFT PALATE-CRANIO-FACIAL ASSOCIATION
APPROVED TEAM

I, ___[NAME]_____, _____, and a Member of __[Name of organization]_, a cleft-craniofacial team approved by the American Cleft Palate-Craniofacial Association.

On _____, 20__, I examined ___[Patient's Name]___and reviewed his/her medical records. In addition, I examined the proposed treatment plan submitted by Dr. ___[provider's name]___. Copies of the medical records and treatment plan accompany this document.

As a result of these examinations, I attest that Mr./ Ms. [Patient's Last Name] suffers from craniofacial anomaly. I further attest that the proposed treatment plan will provide surgery and treatment that are medically necessary to improve a functional impairment that results from the craniofacial anomaly.

____SIGNATURE_____

____PRINTED NAME_____

____DATE_____